REMARKS OF
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TO THE
GRAPHICS COMMUNICATIONS INTERNATIONAL UNION

27 FEBRUARY 1990

Good morning. It is a pleasure to be with you here today, and to have an opportunity to talk to you about health insurance.

Just a few years ago, this would have been an issue of little interest to most union members. Especially since the Second World War, unions like yours have, through aggressive collective bargaining, have obtained health care coverage for your members and their families.

But the world of health care and health insurance has changed. Collective bargaining -- no matter how aggressive -- may no longer be enough to protect existing health benefits.
A few years ago, AFSCME, a major service employee union, reported at a Congressional hearing that: "We're often able to maintain current level of benefits for our members but winning major improvements in access is difficult."

Even that is changing now. A recent study found that disputes over health coverage were a central issue for 78 percent of

strikers in 1989. And that's all over the nation, from miners in Virginia to phone workers in California. Because when you sit down to bargain, the proposals coming across the table are almost always about fewer benefits, higher co-payments, and more deductibles or premium contributions. What you're caught in is a nationwide game of pin the health care cost tail on the donkey. No one's really got the leverage to control costs. Instead, insurers, employers, HMOS, Medicare, and Medicaid are all trying to shift costs onto someone else. And at the bargaining table, management's trying to pin the health care cost tail on you.

My own prediction is that the financing and delivery of health care are in for major changes in the 90's. I hope that the changes come sooner rather than later. But whatever the timing, they will come, because we just can't go on this way.

This year we will spend $621 billion, or 10.7 percent of our GNP, on health care. If current trends continue, by the year 2000, we will be spending $1.5 trillion or 14.1 percent of GNP on health care -- without any reduction in the number of uninsured. Think about this when you consider the next fact:

Between 31 and 37 million people in this country -- 13 to 18 percent of the non-aged population -- are uninsured. Of those, 80 percent are workers or their families.

Let me say that again: In our job-based health care system,

25 to 28 million gainfully employed Americans and their spouses and their children have no health care coverage whatsoever.

Or look at it another way. Between 8 and 10 million children -- 13 to 16 percent of all kids -- are uninsured. No private coverage. No Medicaid. These are the kids who will be the work force when I and most of you are on Social Security. We are making no investment in their health. Among our international competitors, only South Africa is so shortsighted.

It just can't go on this way.

If this weren't enough, the small business insurance market is collapsing. And as the trend towards privatization and contractual employment continues, this is a problem that will affect many of you. It seems that rather than spreading the risk, insurers in the market are doing all they can to avoid it through medical underwriting and similar risk-selection techniques.

A few months ago, my Subcommittee held a hearing on this issue. We heard from Karen Allen, a 47-year-old worker in a 2-person floor covering firm in a Maryland suburb. The firm paid coverage for Ms. Allen, her daughter, and the other employee, at a total cost of $325 per month, effective November 1st, 1987. The next year the premiums were raised 23 percent to $401 per month, and the firm was notified that all preexisting conditions for new employees and dependents would be excluded. During that year,

Ms. Allen had surgery for an herniated disc at G.W. University Hospital. The insurer promptly notified the company that its 1989 rates would be increased to a total of $743 -- an increase of 130 percent in just 2 years.

Ms. Allen's weekly salary is $250. After taxes, her health insurance premiums represent 50 percent of her total take home pay. What are her options? She could lower that premium by switching to a policy with a $1000 deductible -- or a month's gross salary. That will teach her to get sick.

And let's remember. She's lucky. Her employer actually offers coverage, at least for now. And he hasn't fired her.

Lorraine Colletti's dad didn't fare so well. Lorraine is a 13-year old who is fighting a cancerous brain tumor. The St. Petersburg Times reports that her father was recently fired from his job at a small Tampa company, which said that his work was unacceptable. It is remarkable, though, that the firing of this 8-year employee came 3 days before the company had to make a special premium payment for him of $2,774.

Finally, as the New York Times recently reported to us, many insurers are blacklisting certain types of small businesses and professions. And it's not just those lines of business in which employees are perceived by insurers to be at greater risk for AIDS, such as entertainment and arts groups and beauty salons.

It's also a lot of stores on the main street of our economy's service sector: hotels, motels, restaurants, car washes, laundries, cleaners, bowling alleys, lumberyards, pest control services, service stations, convenience stores, farms, golf clubs, ski resorts, and -- of all things -- camps.

And AIDS is still with us. People have a tendency to forget this, but we find ourselves in the midst of the worst epidemic in modern history. There are at least a million Americans infected, and over 60,000 have already died. Both because private insurers are screening these people out and because the disease disables people so quickly, Medicaid is becoming the predominant payor for AIDS care. And while Medicaid pays for the inpatient care of people who get acutely ill with AIDS, it won't pay for the preventive care to keep infected people from getting acutely ill.

Clearly, the system is not working for a lot of people. It's not working for unions, who are trading wage increases for keeping health benefits. It's not working for big businesses who carry the cost of benefits for uninsured dependents who are working elsewhere. It's not working for hospitals and doctors who must care for uninsured people at a great loss.

It just can't go on this way.

We've spent the last ten years waiting for the invisible hand of the marketplace to solve these problems by itself. It hasn't.

And things have only gotten worse.

America has begun to realize that we can't wait anymore. Both the public and private sector have started offering proposals for change: big business, healthcare experts, unions, Congressional representatives. And now we have a new actor on the scene -- the U.S. Bipartisan Commission on Comprehensive Health Care, or the Pepper Commission. Why is this commission so important? Because it is composed of the major players on the Congressional committees that will finally decide how to change the health care system.

I don't know at this point precisely where the Commission will come out. But I'd like to share with you some of my thoughts on how we create a health care system that can improve the health status of our people without bankrupting us all.

I would begin by building on the existing job-based system of health care coverage. If we were starting from scratch, I might not want to tie health care coverage to employment. But we're not starting from scratch. Most of those who have insurance coverage in this country have it through their workplace. In my judgment, the only realistic course is to start where we are and improve upon it.

My improvements would be along the following lines. First,

I'd require all employers, large and small, either to offer their employees and dependents a basic set of benefits, or to contribute a percentage of their payroll toward a public plan. Thus, health care coverage would become a cost of business for all employers; no employer could undercut the competition by denying coverage to its workers and their families.

Now it would be completely unreasonable to require employers to offer coverage without making some major changes in the marketplace in which they have to purchase that coverage.

-- Employers need access to basic coverage at an affordable price. This means requiring insurers to offer basic policies without medical underwriting and without experience rating.

-- They need some way to limit provider price increases. This means giving the purchasers of health care the leverage to negotiate effectively with hospitals and physicians.

-- They need protection against mandates of additional benefits imposed by States. This means preempting State minimum benefits laws with a uniform Federal basic benefit requirement.

Now there are a fair number of people who would not be reached by the employer-based system -- part-time workers, the unemployed, and the poor. For these people, and for the workers of those employers who elect to pay the contribution rather than offer coverage, I would establish a new public plan.

Specifically, I would replace the Medicaid program with a Federally financed, Federally administered entitlement program offering a uniform basic benefit package throughout the country. This new program would not be only for the poor. It would be completely divorced from the welfare system, and private employers would be able to buy their employees into it if they chose to do so. It would pay providers far more reasonable compensation for their services than many State programs now do.

Any program we enact will have to include cost controls. What we've got now is a game in which each payor looks out for itself, and costs get shifted, not contained. This can't continue, particularly if we are going to put large amounts of additional Federal and employer dollars into the system to pay for the uninsured.

Even with effective cost controls, this new public program will cost money. Depending on how it is structured, and on how many employers opt not to offer their employees private

coverage, the costs could range from about $28 billion to $45 billion per year.

That's a lot of money, of course. But not when you consider the scope of the overall economy. Not when you realize that's roughly equal to a 15 percent reduction in our current defense budget. I think, given the change in global politics, the American people would gladly reduce the billions we pour into defense, and put some of that money into the domestic issues that matter most to us.

Because the question is not really can we afford to reform the health care system. The question is: how can we afford not to?

In closing, let me say that there are three major tasks facing Congress as we approach health issues this year. First, we must maintain our focus on the sorry state of our health care system. It might be OK in the Bush administration to keep watching the President's lips, but I think that most Americans would rather look at the real problems that real people have.

Second, we must move ahead on the broad solutions that will truly reform the way health care is delivered and financed. The longer we wait, the worse it will be.

Finally, we must continue the progress we make every year on the health programs we already have, from revitalizing the regulatory role of the FDA, to supporting our public health and research agencies, to combatting the AIDS epidemic. These programs are the backbone of a healthy nation, and we must not neglect them.

Thank you for having me here with you this morning. I look forward to working with you on all of the important health issues we face.